11.

Iliac or so-called Inguinal Colotomy.

By T. VINCENT JACKSON, F.R.C.S.,

Surgeon to the Wolverhampton and Staffordshire General Hospital, &c., &c.

Reprinted from the "Medical Press and Circular," May 15, 1889.

London:
JOHN BALE & SONS, 87-89, GREAT TITCHFIELD STREET,
OXFORD STREET, W.
1889.

Iliac or so-called Inguinal Colotomy.

THE return to the preferential performance of iliac or so-called inguinal colotomy is due to the increasing confidence which is generally felt that the peritoneum may now be incised without the danger, risk, and mortality which induced Calissen in 1796 to suggest the extra-peritoneal operation of exposing and opening the left colon, and who, in the next year, 1797, was followed by Pilore, who made an artificial anus on the right side by opening the cæcum. In 1839 Amussat improved Calissen's operation by advising that the external incisions, instead of being longitudinal, should be made transversely. For many years Amussat's lumbar colotomy was the operation *par excellence* usually selected when, for any cause, an artificial anus was required. Of late the stereotyped advantages of Amussat's operation, which are to be found recorded in every text-book of the day, have been contested ; the accumulated experience of many practical surgeons pointed to several disadvantages—the least being its high mortality, and which the colotomy statistics of Von Erckelens showed was at least 38.4 per cent., so that Fludsguard, Verneuil and Reeves suggested, and indeed revived, the performance of Littré's operation (originally proposed in 1710) of inguinal or intra-peritoneal colotomy.

In August, 1887, at the Dublin meeting of the British Medical Association, Mr. H. W. Allingham forcibly and convincingly directed attention to the advantage of inguinal over lumbar colotomy, and there can, I think, be little doubt that Mr. Allingham's paper (*British Medical Journal*, October, 1887), has more distinctly aroused a consideration of the benefits accruing from the performance of anterior colotomy, as well as the advantages of the procedure which Mr. Allingham states he has found the most advisable for the more efficient performance of the operation than any other publication upon this subject which has preceded it. To the continued use of the expression inguinal colotomy, I must be allowed to demur. The word inguinal is derived from the Latin inguinalis, belonging to the groin; the word groin is usually supposed to indicate the place or junction of the abdomen and the anterior part of the thigh, an anatomical region, therefore, which is not invaded when the colon is opened in front. I would suggest as the more correct definition of what is now understood by the words "inguinal colotomy," that whilst posterior colotomy is spoken of as lumbar, anterior colotomy should be called "iliac," borrowing the name as before from the exact anatomical region in which the incisions are mainly made, to effect the necessary abdominal section, whereby the peritoneum is incised, the colon prolapsed, and finally fixed to the divided parts.

The operation of iliac colotomy as now practised is in many important particulars a totally different operation to that proposed by Littré (1710), and first successfully performed by Dinet (1793), also by Freer and Pring (1821), and it is on account of these differences that it owes the success which it is reported to have achieved in the hands of Allingham, Cooper, Bond, Chavasse, Arnison, &c.

Littré's operation was performed as follows: "A cut from one inch and a-half to two inches long is to be made from behind, so that its lower end should be a little below the upper front iliac spine and half an inch from it, and continued layer after layer through the skin and muscles; the peritoneum is then opened, raising it with the forceps, and the sigmoid flexure of the colon sought for, drawn to the wound, two waxed threads carried round it, and a longitudinal cut having been made in it, returned into the belly, and by means of the threads retained between the edges of the external wound with which it unites."

Mr. Allingham says (*British Medical Journal*, October 25, 1887, p. 875): "The manner in which I now perform this operation is by making an incision two inches in length, about one inch inside the anterior superior spine of the ilium and parallel with Poupart's ligament. The abdominal muscles are divided and bleeding stopped: on reaching the peritoneum a small incision is made into it, and the cut edges taken hold of with clip forceps, and held up by the assistant. Scissors are then used to cut through the peritoneum to the size of the wound." . . . "A flat sponge is next introduced to keep the intestines out of the way and to catch any blood that might otherwise drain into the abdomen, while the parietal peritoneum is being carefully sewn with interrupted fine carbolised silk to the skin all round." . . . "The sponge being removed, a search is made for the sigmoid flexure" . . . "when the gut is found and brought to the surface" : . . "I pull up as much of the gut as possible and stitch it to the wound so that the intestine when opened (some days later) looks like the orifice of a double-barrelled gun."

The recital of the two methods of performing an operation as first proposed in 1720, and as revived and practised

in 1887, is interesting, and the comparison instructive, and the conclusion we are driven to is the almost self-evident one, viz., that presuming the skill was equal, the earlier operators failed of success because they were less educated than we are in the importance of attending to the most minute detail from the standpoint of cleanliness of the patient and his or her surroundings, of the operator, the assistants, the instruments and appliances. The comparative merits of lumbar and iliac colotomy have been summed up differently and in some respects apparently from the proclivities and the operating results which the various surgeons who have estimated their capabilities have possessed and obtained. During the performance of iliac colotomy the patient lies on the back, a position convenient to the surgeon, and certainly more safe for the administration and inhalation of an anæsthetic. The wound being short, superficial, clean cut, and almost unhandled, heals quickly, and what redressings are required are applied without the slightest inconvenience, fatigue, pain, or disturbance. The front position of an artificial anus is commended by those who unfortunately have had to experience its benefits and its discomforts, inasmuch as they can at all times lie on their back or side, and they are more independent of help, and personally more reliant than if the opening was in the loin.

The most trying proceeding in connection with iliac colotomy is the hooking of the sigmoid flexure before it can be prolapsed, and this in my opinion is far more difficult to accomplish than is generally admitted. Both on the dead and on the living I have had considerable experience of this operation, and though I have always succeeded in satisfactorily completing it, yet I have frequently been baulked in my endeavours to find the sigmoid colon, and no method has answered the purpose better than

passing the forefinger of the right hand within the abdomen from the front to the back of the iliac fossa, where it immediately comes upon the large intestine, and which is then with ease and precision brought forward until it becomes extra-abdominal. Occasionally, although not more frequently than once in two hundred and fifty cases, as determined by *post-mortem* statistics, the rectum is found on the right side, an abnormality which must not be forgotten as an occasional occurrence to be met with.

After both varieties of colotomy the artificial anus is liable to contract, and in my experience this unpleasantness is as common after the one operation as after the other, although in iliac the patient is far more able than in lumbar colotomy to control and remedy the tendency, either by employing his forefinger or a bougie made for that purpose.

As a rule the malignant disease which involves the rectum does not progress along its entire length, and rarely will it be prohibitory to the successful completion of iliac colotomy, although the possibility of it so doing must not be absent from the mind of the operator. The one drawback, and the great disadvantage of iliac colotomy lies in the fact that the peritoneal cavity is opened, that the operation is intra-peritoneal, whilst the great point in favour of lumbar colotomy is that it is extra-peritoneal; but looking to the large measure of success which has already attended the performance of the former operation, it must, I think, be conceded that the presumption, or the *a priori* argument that it is more dangerous and risky is not borne out by statistics, and further, that in all probability its present low mortality will even be a lessening quantity. As a practical point worth remembering, I may mention that I always attach to the sponge, which is placed beneath the wound and over the intestines, a piece of fine silk, as in one of my

cases, owing probably to the movement of the small intestines, induced by deep and somewhat rapid respiration, the sponge became displaced, and was only recovered after some little searching for. In nearly all the steps of its performance, iliac colotomy resembles the operation of gastrotomy, the lines upon which the latter operation is undertaken being identical with those which Mr. Allingham suggests as being best for the former. The same surgeon lays great stress upon what he calls, apparently after Verneuil, the making of a spur, and he somewhat complicates and lengthens the operation by recommending a special method for its production. I have not found the plan recommended necessary; the important point being to pull forward "a knuckle" of bowel and stitch its outer coats at short intervals to the parietal peritoneum of the skin, and if after the gut has been opened, and the artificial anus works, there is too much protrusion, it can be pared down to the skin level with scissors.

Some surgeons are inclined to limit the application of iliac colotomy to cases of malignant stricture of the rectum, when accompanied with pain of a severe character and other distressing symptoms, but unaccompanied with obstruction of the bowels. Personally I think it is unwise to lay down hard and fast lines in reference to what should or should not be done in any given condition, each case should be treated *sui generis;* and while no doubt, in the major number of cases of obstruction of the bowels, lumbar colotomy would be preferable, yet possibly there are some few cases in which iliac colotomy should be selected as the better operation.